DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-008

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1,2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Sections 447.296-447.299

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 0
b. FFY 2001 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A Pages 3, 17-27

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 419A Pages 3,17-26

10. SUBJECT OF AMENDMENT:
DSH payment

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Grant A Buck, for

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Medicaid Administrator

15. DATE SUBMITTED:
August 28, 2000

16. RETURN TO:
HHS Finance & Support
Medicated Division
Atten: Dana McNeil
P.O. Box 95026
Lincoln, NE 68509-5026

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
08/31/00

18. DATE APPROVED:
FEB 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Raymond
Seiffert
CO

SPA CONTROL

Date Submitted 08/30/00
Date Received 08/31/00

Disproportionate Share Hospital (DSH): A hospital is deemed to be a disproportionate share hospital by having:

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified as a distinct part unit for Medicare. Neonatal units will be recognized if they meet the criteria for a Level III neonatal intensive care unit (NICU) set forth by the American Academy of Pediatricians and American College of Obstetricians and Gynecologists in "Guidelines For Perinatal Care" Third Edition (1992). Hospitals must submit documentation to substantiate that the unit meets the criteria of a Level III NICU prior to such designation. During the initial base year, the Department will accept the Medically Handicapped Children's Program (MHCP) designation of a unit in or after 1991 as a Level III NICU as meeting this requirement.

DRG Weight: A number that reflects relative resource consumption as measured by the relative charges by hospitals for discharges associated with each DRG. That is, the Nebraska-specific DRG weight reflects the relative charge for treating discharges in all DRGs in Nebraska hospitals.

Hospital-Specific Base Year Operating Cost: Hospital specific operating cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, in accordance with appropriate Medicare regulation and exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Indirect Medical Education Costs Payments: Payments for costs that are not directly associated with running a medical education program, but that are incurred by the facility because of that program.

10-010.03E1 Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as the median of the hospital-specific base year operating cost (in accordance with the methodology described in 10-010.03B3) per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units. Per diem amounts are arrayed in descending order, and the peer group median is determined.

10-010.03E2 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem (see 471 NAC 10-010.03B7).

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Effective for cost reporting periods beginning after July 1, 1999, payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Medicaid pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. The certification is required no later than one day before the date on which the bill for inpatient CAH services is submitted to NMAP. Certifications need not routinely be submitted with inpatient bills, but should be retained at the CAH and made available on request to NMAP.

Subject to the 96-hour limit on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients. The part of an inpatient stay that exceeds 96 hours will be covered if it is considered medically necessary, and the CAH documents either that transfer of the patient to a hospital is precluded because of weather or other emergency conditions, or a PRO or equivalent entity has, on request, waived the 96-hour restriction with respect to the specific case.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for NMAP. This requirement does not apply to a hospital:
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.

   For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. A filed Medicare Cost Report (prior to June 30th, the end of the previous state fiscal year from which payment is being calculated); and
3. The actual charges billed for services provided to indigent individuals who had no insurance or third party coverage. The required information must be from the same period reported in the Medicare cost report.

Hospitals reimbursed on a cost basis are not eligible for DSH payment and will not be considered in determining the mean Medicaid inpatient utilization rate.

10-010.03H1 Disproportionate Share Payment:

Disproportionate share payments will be made one time during each state fiscal year. The Department will annually determine the DSH payments in January for the current State fiscal year. The payment will not be subject to settlement or revision based on changes in utilization during the year to which it applies. Payments determined for each state fiscal year will be considered payment for that year, and not for the year from which data used in the calculation was taken.

1. Calculation of payment adjustment:
   a. Each hospital's eligibility for DSH payment, and the amount of the DSH payment, will be calculated using the most recent completed and filed Medicare Cost Report and completed required information submitted prior to the ending of the previous State fiscal year (June 30th). Data for that cost report period will also include the MMIS claims file data run 150 days after each hospital's fiscal year end.

b. For each hospital, the Medicaid shortfall (DSH payment) will be calculated by subtracting total Medicaid payments from total Medicaid costs. For those hospitals reimbursed on a cost basis, Medicaid shortfall equals zero.
c. For each hospital, the total allowable Medicaid costs will include: 1) fee-for service Medicaid inpatient costs, 2) fee-for-service Medicaid outpatient costs, 3) total Medicaid inpatient and outpatient managed care costs (means the actual cost to the hospital of care rendered to Medicaid recipients enrolled in a managed care plan), and 4) the total cost of uncompensated care (cost of care for indigent individuals who have no insurance or other source of third party coverage).
d. For each hospital, the total Medicaid payment will be determined by calculating the sum of payments to include payments as reported by Medicaid Management Information System, managed care payments, and payments made by private insurance for Medicaid recipients.

2. Limitations on disproportionate share payments:
   a. No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923 (g)(1)(A) of the Social Security Act.
   b. A payment adjustment (DSH payment) during a fiscal year will not exceed the sum of Medicaid allowable costs less the sum of Medicaid payments for services during the year from which the data for the DSH payment calculation is taken .
   c. Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act. If the total of all disproportionate share payment amounts for all DSH hospitals exceeds in any given state fiscal year the federally determined disproportionate share allotment for Nebraska, the DSH payments will be reduced proportionately among DSH hospitals to a level in compliance with the federal disproportionate share allotment.
   d. To be considered eligible as a Disproportionate Share Hospital, the required information must be completed, signed, dated, and submitted with the hospitals filed Medicare Cost Report.

e. Institution for Mental Disease (IMD) DSH payments may not exceed the lesser or Mental Health DSH expenditures applicable to the 1995 DSH allotment as reported on the HCFA 64 as of January 1, 1997; or the amount equal to the product of the State's current year total computable DSH allotment and the "applicable percentage". For state fiscal year 1998-2000, the "applicable percentage" is defined as the ratio of 1995 total computable share mental health DSH payments (applicable to the 1995 DSH allotment) to the 1995 total computable share total DSH expenditures (applicable to the 1995) DSH allotment). For state fiscal year 2001, 50%; for fiscal year 2002; 40%; for each succeeding fiscal year, 33%.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals with 100 or more acute care beds located in Metropolitan Statistical Area (MSAs) as designated by Medicaid.
2. Rural Acute Care Hospitals: All other acute care hospitals;
3. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in these regulations.
4. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in these regulations.

Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. The cost-to-charge ratio is the peer group average.

Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate.

10-010.03J1 Exception: The Administrator of the Medical Services Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that -

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the NMMCP are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are not required, but are authorized to pay providers of hospital inpatient services who care for individuals enrolled in the NMMCP at rates the Department would otherwise reimburse providers under this section.

10-010.03L Free-Standing Psychiatric Hospitals: When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill NMAP for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to 471 NAC 10-010.03C, Computation of Rate and/or 10-010.03J, Out-of-State Hospitals. This is an exception to policies related to the elimination of combined billing in 471 NAC 10-003.04D and following.

10-010.03M Rate-Setting Following a Change in Ownership: The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

10-010.03N Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1 - 7. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital on a cost basis system in accordance with Medicare rules. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals with 100 or more acute care beds located in Metropolitan Statistical Area (MSAs) as designated by Medicaid.
2. Other Urban Acute Hospitals: Hospitals with less than 100 acute care beds located in a Medicare-designated MSA and hospitals that have been redesignated to an MSA by Medicare;
3. Rural Acute Care Hospitals: All other acute care hospitals with 30 or more base year Medicaid discharges;

4. Excluded Rural Acute Care Hospitals: Hospitals with less than 30 Nebraska Medicaid discharges in the base year;
5. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the Nebraska Department of Health and distinct parts as defined in these regulations;
6. Rehabilitation Hospitals and Distinct Part Units: Hospitals that are licensed as rehabilitation hospitals by the Nebraska Department of Health and distinct parts as defined in these regulations.
7. Critical Access Hospital: Hospitals which (1) maintain no more than 15 inpatient beds, except as permitted for CAHs having swing-bed agreements; (2) are located outside any area that is a Metropolitan Statistical Area or that is recognized as urban; and (3) are certified by HCFA as a Critical Access Hospital.

10-010.03P Depreciation: The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

10-010.03Q Recapture of Depreciation: A hospital which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department; or
2. The product of -
   a. The ratio of Medicaid allowed inpatient days to total inpatient days; and
   b. The amount of gain on the sale as determined by the Medicare intermediary.

$$\frac{\text{\# of Medicaid Inpatient Days}}{\text{Total \# of Inpatient Days}} \times \text{Gain on Sale in \$} = \text{Recapture Amount}$$

The year(s) for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

10-010.03R Adjustment to Rate: Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current and/or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the underpayment amount as determined by the Department to the hospital.

10-010.03S Lower Levels of Care: When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year.

When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process (PASP), the Department may pay for the PASP days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the PASP days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill for class of care 81 and enter the prior authorization document number from Form MC-9 on Form HCFA-1450 (UB-92). The claim for the PASP days must be separate from the claim for the inpatient days paid at the acute rate. The PASP days will be disallowed as acute care days and NMAP will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the PASP day. PASP days will not be considered in computing the hospital's prospective per diem rate.

10-010.03T Access to Records: Hospitals shall make all records relating to the care of Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, and/or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

Hospitals shall allow authorized representatives of the Department of Health and Human Services Finance and Support, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital shall allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.

10-010.03U Audits: The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

10-010.03V Provider Appeals: A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2-003 ff. A hospital may also request an adjustment to its rate (see 471 NAC 10-010.03V).

10-010.03W Request for Rate Adjustments: Hospitals may submit a request to the Department for an adjustment to their rates for the following:

1. An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate.
2. Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. Extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. Extraordinary circumstances are limited to -
   a. Changes in routine and ancillary costs, which are limited to -
      (1) Intern and resident related medical education costs; and
      (2) Establishment of a certified Level III NICU;
   b. Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.

3. Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
   a. One-time occurrence;
   b. Less than twelve-month duration;
   c. Could not have been reasonably predicted;
   d. Not of an insurable nature;
   e. Not covered by federal or state disaster relief;
   f. Not a result of malpractice or negligence.

In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital.

If an adjustment is granted, the peer group rates will not be changed.

In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following:

1. Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.
2. Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.
3. The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

Requests for rate adjustments must be submitted in writing to the Administrator, Medicaid Division, Health and Human Services Finance and Support. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the Administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted (except for corrections of errors in rate determination). If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.

10-010.03X Administrative Finality: See 471 NAC 3-001.09.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.